PLEASE DO NOT STAPLE IN THIS AREA

[redacted]

Example 2:
Initial Oral Screening in Conjunction with an office visit

HEALTH INSURANCE CLAIM FORM

PICA ☐ ☐ PICA ☐ ☐

CARRIER

1. MEDICARE ☐ (Medicare #) | MEDICAID ☐ (Medicaid #) | CHAMPUS ☐ (Sponsor's SSN) | CHAMPVA ☐ (VA File #) | GROUP HEALTH PLAN ☐ (SSN or ID) | FECA BLK LUNG ☐ (SSN) | OTHER ☐ (ID)

1a. INSURED'S I.D. NUMBER (FOR PROGRAM IN ITEM 1): 987654321A

2. PATIENT'S NAME (Last Name, First Name, Middle Initial): Patty, Peppermint

3. PATIENT'S BIRTH DATE MM DD YY: 05 10 01 | SEX M ☐ F ☒

4. INSURED'S NAME (Last Name, First Name, Middle Initial):

5. PATIENT'S ADDRESS (No., Street): 123 Any Street

6. PATIENT RELATIONSHIP TO INSURED: Self ☐ Spouse ☐ Child ☐ Other ☐

7. INSURED'S ADDRESS (No., Street):

CITY: City | STATE: NC

8. PATIENT STATUS: Single ☐ Married ☐ Other ☐ | Employed ☐ Full-Time Student ☐ Part-Time Student ☐

CITY | STATE

ZIP CODE: 29999 | TELEPHONE (Include Area Code): (919) 555-5555

ZIP CODE | TELEPHONE (INCLUDE AREA CODE): ( )

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER

a. OTHER INSURED'S POLICY OR GROUP NUMBER

a. EMPLOYMENT? (CURRENT OR PREVIOUS) ☐ YES ☐ NO

a. INSURED'S DATE OF BIRTH MM DD YY | SEX M ☐ F ☐

b. OTHER INSURED'S DATE OF BIRTH MM DD YY | SEX M ☐ F ☐

b. AUTO ACCIDENT? ☐ YES ☐ NO PLACE (State)

b. EMPLOYER'S NAME OR SCHOOL NAME

c. EMPLOYER'S NAME OR SCHOOL NAME

c. OTHER ACCIDENT? ☐ YES ☐ NO

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. RESERVED FOR LOCAL USE

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? ☐ YES ☐ NO *If yes*, return to and complete item 9 a-d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED _____ DATE _____

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED _____

PATIENT AND INSURED INFORMATION

14. DATE OF CURRENT: MM DD YY | ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP)

15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. GIVE FIRST DATE MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO MM DD YY

17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE

17a. I.D. NUMBER OF REFERRING PHYSICIAN

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO MM DD YY

19. RESERVED FOR LOCAL USE: 1234567

20. OUTSIDE LAB? ☐ YES ☐ NO | $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (RELATE ITEMS 1,2,3 OR 4 TO ITEM 24E BY LINE)

1. L 382.9 3. L ___.__

2. L ___.__ 4. L ___.__

22. MEDICAID RESUBMISSION CODE | ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

24. A DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B Place of Service	C Type of Service	D PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E DIAGNOSIS CODE	F $ CHARGES	G DAYS OR UNITS	H EPSDT Family Plan	I EMG	J COB	K RESERVED FOR LOCAL USE
1	11 15 YY | 11 15 YY	11	01	99212			80 00	1				
2	11 15 YY | 11 15 YY	11	01	D0150			31 46	1				
3	11 15 YY | 11 15 YY	11	01	D1203			15 44	1				
4	11 15 YY | 11 15 YY	11	01	D1330			15 00	1				
5												
6												

PHYSICIAN OR SUPPLIER INFORMATION

25. FEDERAL TAX I.D. NUMBER SSN EIN ☐ ☐

26. PATIENT'S ACCOUNT NO.: 09878B

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) ☐ YES ☐ NO

28. TOTAL CHARGE $ 141 90

29. AMOUNT PAID $

30. BALANCE DUE $ 141 90

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)

SIGNED Bill Jones, MD DATE 11-15-CCYY

32. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (If other than home or office)

33. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE & PHONE #
Jones Medical Center
123 Any Street
City, State 29999

PIN# 8900000 GRP# 8901000

(APPROVED BY AMA COUNCIL ON MEDICAL SERVICE 8/88) **PLEASE PRINT OR TYPE**

APPROVED OMB-0938-0008 FORM CMS-1500 (12-90), FORM RRB-1500,
APPROVED OMB-1215-0055 FORM OWCP-1500, APPROVED OMB-0720-0001 (CHAMPUS)